IN THE UNITED STATES DISTRICT COURT

FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

GRETCHEN S. STUART, M.D.; *et al.*, Plaintiffs, v. JANICE E. HUFF, M.D. *et al.*, Defendants.	)	Civil Action No. 1:11-cv-804-CCE

DECLARATION OF JOHN M. THORP, JR., M.D., IN SUPPORT OF PROPOSED DEFENDANT INTERVENORS' MOTION FOR INTERVENTION

I, JOHN M. THORP, JR., M.D., declare as follows:

1. I am not a party or related to a party in this action. I am over the age of eighteen and am competent to testify. I am a physician licensed to practice medicine in North Carolina. I received my M.D. degree from East Carolina University Medical School in 1983. My residency training took place at the University of North Carolina (Chapel Hill) School of Medicine in general obstetrics and gynecology (1983-1987). I also completed my fellowship in Maternal-Fetal Medicine at the University of North Carolina (Chapel Hill) School of Medicine in 1989. I received my Master's of Health Sciences in Clinical Leadership from Duke University School of Medicine in 2009.

2. Since 1991 I have been a board-certified obstetrician/gynecologist and since 1992 I have also had a certification in the sub-specialty of Maternal-Fetal Medicine. I am a Fellow of the American Gynecological and Obstetrics Society and a member of the American College of Obstetricians and Gynecologists.

3. I am the Hugh McAllister Distinguished Professor of Obstetrics and Gynecology at the University of North Carolina (Chapel Hill) School of Medicine. I am also a Professor in the Department of Maternal and Child Health, School of Public Health at the University of North Carolina at Chapel Hill. In that role I teach both medical students and residents in Obstetrics and Gynecology. As part of my administrative duties, I have administrative oversight of the Family Planning Fellowship and Residency training programs at UNC. Members of my unit staff the abortion services at our academic health center.

4. I am also an Adjunct Professor in the Departments of Epidemiology at both the School of Public Health at the University of North Carolina and the School of Public Health and Tropical Medicine at Tulane University. I am the Deputy Director of the Center for Women's Health Research, Cecil G. Sheps Center for Health Services Research at both the University of North Carolina School of Medicine and School of Public Health (Department of Obstetrics and Gynecology and Department of Epidemiology, respectively).

5. I am also the Division Director of Women's Primary Healthcare, Program Director of the Women's Reproductive Health Research Scholars Program and Research

Core Co-Director of the Women's Reproductive Health Research Scholars Program at the University of North Carolina.

6. In addition, I am a Fellow of the Carolina Population Center and the Director of the Biomedical Core of the Carolina Population Center of the University of North Carolina at Chapel Hill.

7. I have authored 18 book chapters and serve as a journal referee (reviewer) for 37 different medical journals, including *The New England Journal of Medicine, Mayo Clinic Proceedings, Obstetrics & Gynecology, The American Journal of Obstetrics and Gynecology, British Journal of Obstetrics and Gynecology, Lancet, Journal of Perinatal Medicine* and *Journal of the American Medical Association - Archives of General Psychiatry*.

8. I have published 241 peer-reviewed articles, 133 abstracts discussing medical research, and 36 non-peer reviewed articles.

9. I serve on the Editorial Board of the *Obstetrics and Gynecological Survey* and the *British Journal of Obstetrics and Gynecology*. I have been a principal investigator/researcher and recipient of research grants on 11 major medical research projects totaling millions of dollars.

10. My medical education, training, responsibilities, and publications, are set forth in my *Curriculum Vitae*, a true and correct copy is attached as Exhibit A hereto and incorporated herein by this reference.

11. I have read the Complaint and accompanying declarations filed herein and the recently enacted "WOMAN'S RIGHT TO KNOW ACT" being challenged in that Complaint on the various grounds set forth in this action. (H.B. 854, enacted July 28, 2011, N.C. SESSION LAW 2011-405, the "Act").

12. Providing for and obtaining a woman's full, voluntary and informed consent prior to any medical intervention is the standard of care throughout medicine. Informed consent for elective termination of pregnancy (TOP) is particularly important because women may feel pressured, coerced or ambivalent. The Act regulates the TOP informed consent process and helps ensure that a woman's consent is fully informed and truly voluntary. I seek intervention as a defendant-intervenor in this action on my own behalf, both personally and as a physician, and on behalf of my patients. I do not represent the University of North Carolina School of Medicine at Chapel Hill in this case in any official capacity. "). I am knowledgeable of the facts set forth herein, and if called to testify would truthfully do so, as follows.

Informed Consent in Medicine – The Process

13. Informed consent is integral in all medical practice. It respects the patient's right to know and to be fully informed and thus protects against unwanted medical intervention. It is commonly accepted that informed consent constitutes a process versus an outcome or a signature. The process is enhanced by mutual physician-patient dialogue over time and thereby enhances patient autonomy. Patients have both a right and a duty to be informed. Physicians have a right to convey accurate and objective information and a duty to provide sufficient and material information that a reasonable person would

require in order to make a truly informed choice. The Act conforms to this national standard of care.

14. Physicians also have a duty to not unduly influence a patient's voluntary decision making. Fully informed consent prevents a practitioner from imposing treatments which constitute unethical practice and suggest medical paternalism. This is particularly important concerning TOP given the potential for conflict of interest on the part of the provider. The Act enhances the TOP informed consent process and thereby helps prevent undue physician influence.

15. If informed consent is truly informed, it is based upon accurate and complete disclosure of all relevant and material information as to the nature of the considered treatment, the patient's condition and suitability for this treatment, risks and benefits of the treatment, options and alternatives including non-treatment, description of the treatment and explanation of the likely outcomes. Discussion of the patient's values and beliefs, individual circumstances and context, relationships, and decision making are also important components of this informational sharing.

16. Rarely does a patient refuse information about diagnosis and proposed treatment. If a patient were to indicate a desire to not be informed, such a request would be of genuine concern to the clinician. If such a patient indicated that no further information would be relevant and should not be disclosed by the physician, or if the patient claims to know that which the physician would have disclosed, the degree of reasoning involved in the patient's decision making should be questioned. At its core, patient autonomy requires capacity for rationality and an alleged right to not know is

inconsistent with this well established ethical principle. In these exceptional circumstances, physician non-disclosure of information to a patient does not conform to the practice or aim of ethical medicine, i.e., to assist patients to achieve the optimal autonomy possible. See Ost DE. (1984). The 'right' not to know. *J Med Phil* 1984; 9:301-312. For the patient considering TOP, if full disclosures are not made by the physician or qualified professional, she is less empowered, more at risk of adverse outcomes, and her right to autonomy is diminished.

17. Beyond the information sharing identified above, patient-centered care requires the physician to have knowledge of the patient as "person," including culture, family, prior behavior under certainty, etc. Without this information acquired over time, understanding whether a patient's expressed treatment preference corresponds with their underlying values is largely unknown. See Epstein R & Peters E. Beyond information: Exploring patient's preferences *JAMA* 2011; 302(2): 195-197. Hence, the informed consent process takes time and opportunity and is "relationship-centered." See Epstein R, Alper B & Quill T. Communicating evidence for participatory decision making. *JAMA* 2004; 291(19): 2359-2365.

18. For patients considering TOP, existing time and physician-related constraints preclude relationship-centered communication, in-depth exploration of preferences, complete disclosures of risks, benefits and alternatives, and disclosures of fetal development. Yet in other invasive medical procedures, it is argued that women are often provided more information than they want to know in order to be certain they are

truly informed. See Spear HJ. Regarding abortion: Informed consent or selective disclosure? Nursing Forum 2004; 39(2):31-32.

19. In my medical opinion, based upon my training, experience and familiarity with the medical literature, the Act's informed consent provisions are likely to improve the informed consent process and benefit women contemplating TOP.

The Unique Needs of the Pregnant Patient

20. Elective TOP is unique in medicine in that *two patients* are involved. It is well understood by anyone in our specialty that obstetrician-gynecologists have a duty of care for both of these patients. The TOP decision is irrevocable, and involves the intentional death of one of the physician's patients, i.e., the embryo or fetus. The duty to inform the first patient, the pregnant woman, carries increased informational responsibilities for the physician. In addition, there is the reality of the *relationship* between the pregnant woman and her embryo or fetus. The biological and psychological connection between the mother and her offspring exists regardless of pregnancy intendedness or wantedness.

21. Maternal-fetal medicine has emerged as a result of the high value placed on children, the long-standing duty of the obstetrician-gynecologist to treat both of his/her patients, and improvements in assessment and intervention modalities. See Chescheir, N. (2009). Maternal-fetal surgery: Where are we and how did we get here? *Obstetrics & Gynecology* 2009; 113:717-731. Developments in obstetric medicine during the past two decades have transformed the clinical status of the fetus (see for example: Ananth & Vintzileos, 2006). The treatment of the fetus as a separate patient has been made possible

through improved assessment, imaging, understanding of fetal pathophysiology and the employment of multiple medical interventions including fetal surgeries. See Creasy RK, Resnik R, Iams JD. *Maternal-Fetal Medicine* 6th ed. 2009, Philadelphia, PA: Saunders/Elsevier. Dramatic changes in the management of fetal disorders include interventions using ultrasound-guided needle aspiration through open fetal surgery, use of fetal shunts, blood transfusions, correction of obstructive uropathy with urinary diversion, catheterization and therapy of the fetal heart in utero, and procedures to repair congenital diaphragmatic hernias or neural tube defects. Some interventions are now minimally invasive which previously would have been impossible.

22. When an obstetrician proposes to perform any procedure or treatment on a pregnant mother, the risks to both her and her embryo or fetus fall under the umbrella of what a reasonable patient would want to know. Full and accurate disclosure of those risks to both patients is universally accepted in the ethical and legal practice of obstetrics. The mother assumes the role of proxy for her unborn child because a reasonable patient wants and needs to know the risks to both patients. Because of the unique nature of TOP and its many different interests and considerations, in my opinion the information disclosures and the consent process need to be conducted with even greater care and diligence than is required for other medical procedures.

23. Thus, there are three separate interests of the pregnant mother which are of primary concern. First, the mother has her own interest in her relationship with her embryo or fetus. If she surrenders that relationship, she is terminating the life of a separate, unique living human being. Therefore, any decision she makes must be fully

informed and fully voluntary. Second, she has an important interest in making a decision about the welfare and well-being of her embryo or fetus. Accordingly, she must be able to make an informed decision about the embryo or fetus and must fully understand the impact of the procedure on her embryo or fetus. Third, the mother has an interest in her own health and she needs to know truthful and accurate information about the risk to her health if she elects a TOP, and any risks to which she is subject if she carries the child to term.

Ultrasound & Termination of Pregnancy

24. Among other provisions and disclosures, the Act requires that the physician providing the TOP or a qualified professional perform "an obstetric real-time view of the unborn child" and provide "simultaneous explanation of what the display is depicting" at least four hours prior to the termination of a pregnancy. Ultrasound is a common diagnostic test in obstetrics and gynecology and poses no harm or physical pain to the mother or her embryo(s)/fetus(s). It is commonly performed within the context of elective TOP to confirm gestational age, presence or absence of fetal or placental anomalies, and intrauterine location of a pregnancy. In my medical opinion, receiving an ultrasound scan and accompanying descriptive information as mandated by the Act is essential for a woman's consent to be fully formed and voluntary. The resulting benefits for women are many, including detection of ectopic pregnancy, *placenta previa*, and multifetal gestations in which TOP poses additional possibility of harm.

25. The mandated scan and real time descriptions will allow each mother to hear important information she may not otherwise be aware of. This visual depiction of

what she cannot otherwise see, as well as the provision of her individual embryonic/fetal development which she would otherwise not have, can help ensure that she is fully exercising her autonomy as she consents for a TOP procedure. Because this decision is serious, irrevocable, and carries potentially significant future implications, such individualized informational sharing is warranted. From my own considerable medical experience and from the studies I have examined, it is my medical opinion that women who are presented with the objective results of their sonographic examination with an objective explanation of what those results signify are less at risk of having a surgical procedure or medical treatment to which they otherwise would not have consented.

26. Furthermore, it is my expert opinion that it is now the "common practice" of the medical profession in North Carolina to perform an obstetric ultrasound examination and share the "interpretations of its meaning" with the patient, including showing the sonographic images to the patient and explaining to the patient what these images signify, particularly the gestational age, presence of extremities and organs, the cardiac activity, prospect of fetal demise, and the presence of the intrauterine pregnancy, just as is required by the Act. Performance of an ultrasound is "common practice" for women considering TOP in order to obtain necessary information used to determine the gestational age and condition of the embryo or fetus. The age and condition of the embryo or fetus is necessary to properly guide the physician in selection of the appropriate procedure to terminate the pregnancy. It is also my medical opinion that this information is dispositive for a reasonable patient to make a fully informed decision as to whether or not to obtain a TOP.

27. Plaintiffs argue that the ultrasound speech and display requirements of the Act will cause trauma, distress and other adverse reactions in a TOP patient. There is no credible evidence to support these allegations. In the limited research available, most women would prefer to have an ultrasound examination when seeking a pregnancy termination and view this in a positive light as an aid to help them make a better choice. When asked if they would prefer having an ultrasound examination before TOP, the majority would choose to have a sonogram and simultaneously view the image. See Bamigboye AA, Nikodem VC, Santana MA, & Hofmeyr GJ. Should women view the ultrasound image before first-trimester termination of pregnancy? *So Afr Med J* 2002; 92(6): 430-432. Another study revealed that of those women who actually viewed the products of conception after terminating their pregnancy, 83.1% found that viewing did not make it emotionally harder. See Wiebe ER & Adams LC. Women's experience of viewing the products of conception after an abortion. *Contraception* 2009; 80: 575-577. And finally, most women (86.3%) who chose to view the ultrasound found it a positive experience. See Wiebe ER & Adams LC. Women's perceptions about seeing the ultrasound picture before an abortion. *The Eur J Contracept & Repro Health Care* 2009; 14(2): 97-102.

28. For the above reasons, it is my medical opinion that the Act ensures that the required "conversation" between the physician and the patient, based upon a full disclosure of the relevant medical facts, occurs before the patient gives or refuses to give informed and voluntary consent to terminate her pregnancy. The Act sets a legal

standard that meets the minimum national standard of care for disclosure and patient informed consent in the practice of providing abortions.

Waiting Period Provisions of the Act

29. It is not uncommon for women with a crisis or unintended pregnancy to feel pressured or coerced by her sexual partner or friends to seek a TOP and be unaware of alternatives. These women are at risk of being rushed to treatment. Ambivalence is also a common theme expressed by many women. The Act can help these women and others by giving them increased information and time to reflect and talk with others. The Act requires three different waiting periods: (a) a woman may obtain an obstetric ultrasound 72 hours prior to her TOP and not have to receive another one prior to her pregnancy's termination; (b) certain informational disclosures must be provided 24 hours prior to receiving a TOP; and (c) if a woman has not obtained an obstetric ultrasound in the previous 72 hours, she must receive one at least 4 hours prior to obtaining her TOP. Given the number of issues women consider in addressing a crisis pregnancy, the gravity of the decision, and the emotionality and stress involved, taking sufficient time to reflect on the information provided, share thoughts, examine options, and to process feelings and beliefs is reasonable and prudent. In my medical opinion, it is highly unlikely that these waiting periods will cause an undue burden on women seeking TOP nor will they cause any significant delay in obtaining a TOP or increased health risk.

30. When women are pressured or rushed to treatment, or if they do not take sufficient time to consider the loss of their unique embryo/fetus and its attendant meaning, in my experience, they are at increased risk of adverse psychological outcomes

including resentment, anger, frustration, anxiety and depression. See Broen AN, Moum T, Bodtker AS & Ekeberg O. Reasons for induced abortion and their relation to women's emotional distress: A prospective, two-year follow-up study. *Hospital Psychiatry* 2005; 27:36-43. The Act helps protect a woman from being forced against her will to have a TOP by providing reflective time and disclosures which are truthful, relevant and non-misleading.

31. Where this is no state law requiring a TOP waiting period, in my experience, TOP clinics typically provide their services on a same day basis, where diagnosis, counseling, and TOP occur in a very short window of time. Thus, the relationship between a TOP provider and a woman begins and ends on the same day and there is generally no prior physician-patient relationship. In the absence of the Act, this short window into a woman's life and her history and circumstances makes comprehensive counseling most difficult, if not impossible. In my opinion, this is a serious deficiency in TOP services and is not standard of care in medical practice.

The Medical Risks Associated with TOP

32. Implicit in the discussion of TOP complications is the presupposition that pregnancies are located within the uterine cavity. Women presenting with ectopic pregnancies for TOP procedures can be misdiagnosed and suffer serious sequelae if an ectopic pregnancy is not recognized. Accurate menstrual and contraceptive history and ultrasonographic assessment are essential in discovering ectopic pregnancies.

33. While TOP complication rates tend to increase proportionately with gestational age, the magnitude of risk remains small. After 16 weeks, risks from TOP may exceed the risks of carrying a pregnancy to term and certainly do so by 20 weeks. Obstetric ultrasonography assists in the correct dating of a pregnancy which is standard of care.

34. Implied in any discussion about the complication rates of TOP compared to childbirth is the presupposition that the data upon which they are based is accurate and complete. This is not insignificant as there are only two sources of data for TOP complications: the Centers for Disease Control (CDC) and the Guttmacher Institute (GI). Throughout its history, the latter has been affiliated with or funded by the largest TOP provider in the U.S., Planned Parenthood Federation of America. The CDC relies upon state health department data which is subject to considerable underreporting by TOP providers due to the voluntary nature of the reporting. Likewise, GI's reporting is based upon provider estimates and is subject to conflict of interest issues in reporting adverse TOP outcomes. In the U.S., only about one-third of TOP patients return for follow-up care (Henshaw, 1999), so complications, delayed or otherwise, are unlikely to be known to the TOP provider. There is no national mandatory reporting of the incidence of elective TOP or its complications. In short, there are numerous and complex methodological factors that make a valid scientific assessment of TOP mortality impossible: incomplete reporting, definitional incompatibilities of measures, voluntary data collection, investigator bias, reliance upon estimations, inaccurate and/or incomplete death certificate completion, and incomparability with maternal mortality statistics. For

these reasons, a meaningful comparison between the risk of TOP and carrying a pregnancy to term is precluded at this time.

Medical & Psychological Complications of Abortion

35. Short-term physical harms from TOP include bleeding, infection, incomplete abortion, and damage to bowel, bladder, or upper genital tract. While long-term harms are understudied and conflicting results have been reported, growing evidence suggests an increased risk for certain adverse outcomes: mood disorders, substance abuse, and breast cancer (Thorp JM Jr, Hartmann KE, Shadigian E. Long-term physical and psychological health consequences of induced abortion: review of the evidence. *Obstet Gynecol Surv* 2003; 58: 67-79), depression, anxiety, suicidal behaviors and substance use disorders (Ferguson DM, et al. Abortion in Young Women and Subsequent Mental Health, *J Child Psychol & Psychiat.* 2006; 47: 16 – 24 and Fergusson DM, Horwood, LJ & Boden J.M. Abortion and mental health disorders: Evidence from a 30-year longitudinal study. *Br J Psychiat*, 2008, 193: 444-451), and posttraumatic stress disorder, agoraphobia, alcohol and drug abuse, and major depression (Coleman, PK, Coyle CT, Shuping M, Rue VM. Induced abortion and anxiety, mood, and substance abuse disorders: Isolating the effects of abortion in the national comorbidity survey. *J Psychiat Res* 2009, 43:770-776 & Corrigendum in *J Psychiat Res* 2011, 45:1133-1134). In the largest meta-analysis of the mental health and TOP literature to date, when compared to women with an unintended pregnancy delivered, women with TOP had a 55% increased risk of experiencing mental health problems. Nearly 10% of the incidence of all mental health problems under study was reported to be directly attributable to TOP See Coleman

PK. Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009. *Br J Psychiat*. 2011, 199:180–186. In my experience, these psychological complications are more likely to occur when a patient is misinformed or uninformed in her TOP consent.

36. Increased risk of breast carcinogenesis after TOP may result from the loss of protection that carrying a pregnancy to term may involve for younger women. See Thorp JM Jr, Hartmann KE, Shadigian E. Long-term physical and psychological health consequences of induced abortion: review of the evidence. *Obstet Gynecol Surv* 2003; 58: 67-79.

37. One clear-cut and substantive long-term harm of TOP is an increased risk of preterm birth (PTB). See Calhoun BC, Shadigian E, Rooney, B. Cost consequences of induced abortion as an attributable risk for preterm birth and impact on informed consent. *J Reprod Med* 2007; 52: 929-937. The relative risk of PTB after TOP increases 2-4-fold. PTB is common so that relative risk may increase a women's absolute risk from 10 to 20%.

Personal Impact of the Act on Me, My Practice & My Patients

38. The informational and medical disclosures required by the Act are relevant and vital to the well-being of pregnant patients considering TOP. Enabling true and fully informed consent is the purpose of this law. In my medical practice my patients rely upon me to accurately and completely inform them so their decisions are voluntary and fully informed. If this case is adversely decided against the State with the law being declared unconstitutional because the disclosures are misleading, ideological, and

inaccurate statements as the plaintiffs allege, I am personally impacted in numerous and significant ways. I now seek to intervene in this matter so that my own interests and those of my patients are adequately protected, litigated and advanced.

39. As a person and as a physician, I have a profound legal, moral and professional duty to provide accurate, truthful and full disclosures to all of my patients. I also have a responsibility and right to speak freely and accurately with my patients. It is evident to me, particularly in light of the facts and allegations involved in this matter, that I have an important interest in protecting my own rights and interests, as well as the rights and interests of my patients and that my rights and interests are inextricably interconnected to theirs. In my medical practice, I have both the right and responsibility to tell the truth.

40. If plaintiffs were to succeed in this lawsuit and have the Act declared unconstitutional because the law required non-truthful and misleading facts or mere ideology, my interests would be significantly and negatively impacted. If this were to occur, it would amount to an affirmation that all of the counseling I have provided was false or misleading and could thereby subject me to the following adverse outcomes: civil liability; possible disciplinary action by the state medical regulatory authority which could include suspension or revocation of my medical license. This would then force me to alter my counseling, require me to make false and misleading disclosures and compel me to stop giving accurate factual and medical explanations. As a result, I would be prevented from speaking freely on what I believe is truthful and accurate information. If I continued to provide what I know is truthful and accurate facts, I would be immediately

subject to all of the sanctions outlined here, not just for past counseling, but also for present and future counseling of my patients. Because the order and decision already entered in this case affirm that the plaintiffs have a fair chance of success since the disclosures are preliminarily determined to be inaccurate or ideological compelled speech, as a matter of fact, I am already exposed to all of the sanctions and liabilities enumerated above, and will continue to be exposed. This is an untenable position in which to be placed. Because I believe that only I can properly protect my legal interests and the interests of my patients so as to properly adjudicate the common questions of law and fact that my claims and defenses share with the claims and defenses being asserted in this case, I hereby seek to intervene in this action as a defendant-intervenor.

41. If plaintiffs succeed in this case, I am deeply concerned that my legal rights and other interests, as well as the legal rights and other interests of my pregnant patients, some of which we hold in common, will be significantly and adversely affected. These legal rights and interests are dependent almost entirely upon the truthful, accurate and complete disclosures being given to them in order for them to make fully informed and voluntary pregnancy related decisions. For example, if plaintiffs succeed in this case, civil remedies that both I and my pregnant patients would otherwise enjoy under Section 90-21.87 of the Act would be unavailable "against the person who performed the abortion in knowing or reckless violation of the Act."

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42. As a defendant-intervenor I will do nothing to unduly delay or prejudice the adjudication of the original parties' rights in this action.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct. Executed on November 7, 2011.

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John M. Thorp, Jr., M.D.

EXHIBIT A:

Curriculum Vitae

of

John M. Thorp, Jr., M.D.

CURRICULUM VITAE
JOHN M. THORP, JR., M.D.

Personal Information

Name John M. Thorp, Jr., M.D.

Department of Obstetrics and Gynecology
3027 Old Clinic Building
CB # 7570
Chapel Hill, NC 27599-7570

Telephone (919) 843 7852

Fax (919) 966-6001

E-mail thorp@med.unc.edu

Education

Master's	Duke University School of Medicine Master of Health Sciences in Clinical Leadership	2009
Fellowship	University of North Carolina School of Medicine Chapel Hill, North Carolina Fellowship in Maternal-Fetal Medicine Fellowship Director: J.W. Seeds	1987 – 1989
Residency	University of North Carolina School of Medicine Chapel Hill, North Carolina Residency in Obstetrics & Gynecology Program Director: W.C. Fowler	1983 – 1987
Medical School	East Carolina University Medical School, M.D. Greenville, North Carolina	1979-1983
College	University of North Carolina at Chapel Hill B.A. Zoology	1975-1979

Certification:

Board Certification	Obstetrics and Gynecology	1991-annually to present
Sub-Specialty	Maternal-Fetal Medicine	1992-annually to present

Professional Experience

Division Director	Women's Primary Healthcare	2006-present
Program Director	Women's Reproductive Health Research Scholars Program	2006 - present
Research Core Co-Director	Women's Reproductive Health Research Scholars Program	2006 - present
Interim Director	Center for Women's Health Research Cecil G. Sheps Center For Health Services Research Department of Epidemiology School of Public Health Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	2006 – present
Professor	Department of Maternal and Child Health School of Public Health University of North Carolina, Chapel Hill, NC	2005 - present
Adjunct Professor	Department of Epidemiology School of Public Health University of North Carolina, Chapel Hill, NC	2004- present
Director	Biomedical Core Carolina Population Center University of North Carolina, Chapel Hill, NC	2004-present
Deputy Director	Center for Women's Health Research Cecil G. Sheps Center For Health Services Research Department of Epidemiology School of Public Health Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	2004-present
Adjunct Professor	Department of Epidemiology School of Public Health and Tropical Medicine Tulane University	2003-present
Fellow	Carolina Population Center University of North Carolina, Chapel Hill, NC	2003-present
Hugh McAllister Distinguished	Department of Obstetrics and Gynecology School of Medicine	2001-present

Professor Ob & Gyn	University of North Carolina, Chapel Hill, NC	
Professor	Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	2000-present
Co-Director	North Carolina Program for Women's Health Research, Cecil G. Sheps Center For Health Services Research Department of Epidemiology School of Public Health Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	1999-2004
Senior Research Fellow	Cecil G. Sheps Center for Health Services Research University of North Carolina, Chapel Hill, NC	1999-present
Co-Director	Institute Generalist Physician School of Medicine University North Carolina-Chapel Hill	1999-2000
Adjunct Associate Professor	Department of Epidemiology School of Public Health University of North Carolina, Chapel Hill, NC	1999 - 2004
Associate Professor	Division of Maternal-Fetal Medicine Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	1995-2000
Associate Chair	Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	1995-1999
Medical Director	HORIZONS Perinatal Substance Abuse Program School of Medicine University North Carolina-Chapel Hill	1993-present
Assistant Professor	Division of Maternal-Fetal Medicine Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	1990-1995
Clinical Assistant Professor	Division of Maternal-Fetal Medicine Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	1989-1990

Honors

University of Rochester School of Medicine Teaching Fellow	2010
Golden Tar Heel Medical Student Teaching Award	2005, 2006
Robert C. Cefalo Excellence in Teaching Professors Award	2004-2005
Hugh McAllister Distinguished Professorship in Obstetrics and Gynecology	2002
Professor Teaching Award Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	1993, 2000
Perinatal Health Model of Excellence North Carolina Department of Health and Human Services in Conjunction with the March of Dimes	1999
North Carolina Division of Mental Health Developmental Disabilities and Substance Abuse Services Recognition Award for Outstanding Service to Women and Children	1999
APGO/CREOG Departmental Teaching Award Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	1992, 1995
Junior Faculty Teaching Award Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	1990, 1992, 1995
Family Medicine Teaching Award Department of Family Practice School of Medicine University North Carolina-Chapel Hill	1989
American Journal of Obstetrics & Gynecology One of the top 100 reviewers for the academic year	2006-2007

Memberships

Fellow, American Gynecological and Obstetrical Society	2004 - present

Vice President, Southern OBG Seminar	2003-present
Southern Obstetrics & Gynecologic Seminar	1994-present
South Atlantic Association of Obstetrics and Gynecology	1994-present
Society for Gynecologic Investigation	1993-present
Association of Professors of Gynecology and Obstetrics	1993-present
Society for Maternal-Fetal Medicine	1984- present
American College of Obstetricians Gynecologists	1983-present

Administrative Accomplishments

Four of six clinicians in Women's Primary Care Division were cited for excellence in graduate and postgraduate medical education	2005
Four of seven clinicians in Women's Primary Care Division were cited for excellence in resident Medical education	

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Book Chapters

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3. **Thorp JM** , Herbert WNP. Pancreatitis in pregnancy. In *Clinical Decisions in Obstetrics and Gynecology*. Cefalo RC (ed). Rockville, MD: Aspen Publishers, 60-2, 1990.

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6. **Thorp JM** Pasteur, Charles. In *Dictionary of North Carolina biography.* Powell WS (ed). U of North Carolina P. Vol 5: p28, 1994.

7. **Thorp JM** Pasteur, Thomas. In *Dictionary of North Carolina Biography.* Powell WS (ed). U of North Carolina P. Vol 5: p28, 1994.

8. **Thorp JM** Pasteur, William. In *Dictionary of North Carolina Biography.* Powell WS (ed). U of North Carolina P. Vol 5: p28, 1994.

9. **Thorp, JM** Management of Drug Dependency, Overdose, and Withdrawal in the Obstetrical Patient. *Obstetrics and Gynecology Clinics of North America,* Accepted 7/94*,* 14 pages.

10. **Thorp JM**, Episiotomy, Clinical Management of Labor, *Churchill Livingstone*, Accepted, 11/94, 20 pages.

11. **Thorp JM** Episiotomy. in Intrapartum Obstetrics, John T. Repke, MD (ed). Churchill Livingstone: New York, 1995.

12. **Thorp, JM**, Prenatal Diagnosis and Therapy. in New Issues in Medical Ethics, Jay Hollman, MD (ed). Christian Medical and Dental Society, Bristol, TN, 1995.

13. Feilder M, **Thorp JM** Radiologic Examinations During Pregnancy. In Drug Therapy in Pregnancy, Third Edition. Jerome Yankowitz & Jennifer R. Niebyl (eds.). Lippincott Williams & Wilkins: Philadelphia PA, 2001.

14. Gwyther RE, **Thorp JM**. Substance Abuse. Netter's Internal Medicine. Marschall Runge & M. Andrew Greganti (eds.). Icon Learning Systems: Teterboro, NJ, 2003.

15. Wilson JK, **Thorp JM**. Substance Abuse in Pregnancy. Clinical Obstetrics, Volume 2, Chapter 33.

16. **Thorp JM**. Clinical Aspects of Normal and Abnormal Labor. Maternal-Fetal Medicine; Principles and Practice, sixth edition, Chapter 36. Robert Creasy and Robert Resnik (eds.): The Curtis Center, Philadelphia, PA, 2007.

17. Garbutt JE, Gwyther RE, **Thorp JM**. Alcohol and Substance Dependence and Abuse. Netter's Internal Medicine 2nd Edition. Marschall S. Runge & M. Andrew Greganti (eds.). Saunders Elsevier, Philadelphia PA, 2009.

18. **Thorp JM Jr**. Chapter 36: Clinical Aspects of Normal and Abnormal Labor. In: Creasy & Resnick's Maternal-Fetal Medicine: Principles and Practice. Sixth Edition. (Robert K. Creasy, Robert Resnik, Jan D. Iams, Charles J. Lockwood, Thomas R. Moore Eds.) Saunders Elsevier, Philadelphia PA, 2009, pp.691-725.

Journal Refereeing

Reviewer	*Journal of Developmental Origins of Health and Disease*
Reviewer	*The Journal of Obstetrics and Gynaecology Research*
Reviewer	*Obstetrics and Gynecology International*
Reviewer	*Human Reproduction*

Reviewer *British Journal of Obstetrics and Gynaecology*
Reviewer *American Family Physician*
Reviewer *Mayo Clinic Proceedings*
Reviewer *Journal of the American Women's Association*
Reviewer *International Journal of Psychophysiology*
Reviewer *Journal of the American Medical Association*
Reviewer *New England Journal of Medicine*
Reviewer *Clinical Anesthesia*
Reviewer *Preventive Medicine*
Reviewer *Journal of Maternal-Fetal Medicine*
Reviewer *Primary Care Field Reviewer's Guide to Substance Abuse Service for Primary Care Clinicians*
Reviewer *Paediatric and Perinatal Epidemiology*
Reviewer *American Journal of Perinatology*
Reviewer *Obstetrics and Gynecology*
Reviewer *American Journal of Obstetrics and Gynecology*
Reviewer *Journal of Pediatrics*
Reviewer *Journal of Perinatal Medicine*
Reviewer *Journal of Perinatology*
Reviewer *Reproductive Toxicology*
Reviewer *Southern Medical Journal*
Reviewer *International Urogynecology Journal*
Reviewer *Medscape Women's Health*
Reviewer *Evidence-Based Preventive Medicine*
Reviewer *JAMA- Archives of General Psychiatry*
Reviewer *OB/GYN Management*
Reviewer *American Family Physician*
Reviewer *Nature Clinical Practice Endocrinology & Metabolism*
Reviewer *The Lancet*
Reviewer *Journal of Psychiatric Research*
Reviewer *Early Human Development*
Reviewer *Canadian Medical Association Journal*
Reviewer *Scientific proposals for AHA*
Reviewer *Women's Health*

Editorial Board

Obstetric and Gynecological Survey	1995-present
British Journal of Obstetrics and Gynaecology	2006-present

Abstracts and presentations:

1. Siega-Riz AM, Savitz DA, **Thorp J**, Bodnar LM. Supplementation use preconceptionally and during pregnancy: does it decrease the risk of preterm births? Poster presentation at the Annual Meeting of the American Public Health Association, Washington, DC, 1998.
2. Siega-Riz AM, Savitz DA, **Thorp JM Jr**, Herrmann T. Meal patterning during pregnancy and its association with preterm births. Oral presentation at the Annual Meeting of the American Public Health Association, Washington, DC, 1998.

3. West S, Yawn B, **Thorp JM**, Korhonen M, Savitz D, Guess H. The efficacy of tocolytic therapy for preterm labor. Presented at the Society for Gynecologic Investigation Annual meeting, Atlanta GA, March, 1999.

4. Saacks C, Wells E, **Thorp JM**. The effects of parturition on immediate puerperal bladder function. To be presented at the Society for Gynecologic Investigation Annual Meeting, Atlanta GA, March, 1999.

5. Pastore LM, Hulka B, **Thorp JM**, Wells E, Kuller J. Postmenopausal vaginal symptoms in relation to douching and smoking. Presented at the Society for Epidemiologic Research Annual Meeting, Baltimore MD, June, 1999.

6. Sayle AE, Savitz DA, **Thorp JM**, Hertz-Picciotto I, Wilcox AJ. Sexual activity during late pregnancy and preterm delivery. Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Baltimore MD, June, 1999.

7. Savitz D, Dole N, Henderson L, **Thorp JM**. Socioeconomic status, race, and pregnancy outcome. Presented at the Society for Epidemiologic Research Annual Meeting, Baltimore MD, June, 1999. Am J Epidemiol 1999;149:S28 (Abstract #111).

8. Forna F, Hartmann KE, Savitz D, **Thorp J**, Buekens P. Early pregnancy bleeding and risk to preterm birth. Poster presentation at the Student National Medical Associatio9n Annual Conference (Second place Clinical Research Award), April, 1999.

9. Herrmann TS, Seiga-Riz AM, Savitz DA, **Thorp JM**. Association between prolonged periods of time without food during pregnancy and preterm birth. Poster presentation at the Society for Pediatric and Perinatal Epidemiologic Research 12th Annual Meeting, Baltimore MD, June 1999.

10. Pastore LM, Hartmann KE, **Thorp JM**, Royce RA, Savitz DA, Jackson TP. Bacterial vaginosis and cervical dilation and effacement at 24-29 weeks' gestation. Poster presentation at The Society for Pediatric and Perinatal Epidemiologic Research 12th Annual Meeting, Baltimore MD, June 1999.

11. Dole N, Savitz D, Hertz-Picciotto I, **Thorp JM**. Stress, social support and pregnancy outcome. Oral presentation at the Society for Pediatric and Perinatal Epidemiologic Research 12th Annual Meeting, Baltimore MD, June, 1999.

12. Pastore LM, **Thorp JM**, Royce RA, Savitz DA, Jackson TP. BV PIN Points: Clinical risk scoring system for antenatal bacterial vaginosis. Annual Meeting of the Society for Maternal-Fetal Medicine, San Francisco, CA, January 1999, and oral presentation at The Society of Perinatal Epidemiologic Research, Baltimore MD, June, 1999.

13. Savitz DA, Runkle ND, **Thorp JM**. Smoking and preterm birth: Evaluation of timing, dose, and etiologic pathway. Poster presentation at the International Scientific Meeting of the International Epidemiological Association, Florence, Italy, August, 1999.

14. **Thorp JM**, Berkman ND, Gavin NI, Hasselblad V, Lohr KN, Hartmann KE. Antibiotics for treatment of preterm labor—review and meta-analysis. Presented at ACOG Annual Meeting, October, 1999.

15. **Thorp JM**, Berkman ND, Gavin NI, Hasselblad V, Lohr KN, Hartmann KE. Maintenance tocolysis for treatment of preterm labor—review of the evidence and meta-analysis. Presented at ACOG Annual Meeting, October, 1999.

16. **Thorp JM**, Hartmann KE, Berkman ND, Lohr KN. Fetal fibronectin and endovaginal ultrasound in the management of preterm labor—a review of the evidence. Presented at ACOG Annual Meeting, October, 1999.

17. McPheeters M, **Thorp JM**, Gavin NI, Hasselblad V, Berkman ND, Lohr KN, Hartmann KE. Hone uterine activity monitoring in the care of preterm labor – a review of the evidence. Presented at ACOG Annual Meeting, October, 1999.

18. **Thorp JM**, Berkman ND, Gavin NI, Lohr KN, Hartmann KE. Acute tocolysis for treatment of preterm labor – review of the evidence and meta-analysis. Submitted to ACOG, October, 1999.

19. McMahon MJ, **Thorp JM**, Savitz DA, Bagchee R. Risk factors for preterm birth. Presented at the Society for Maternal-Fetal Medicine, January, 2000.

20. Strauss RA, Royce RA, Sanasuttipun W, Eucker B, **Thorp JM**. Diagnosis of bacterial vaginosis from self-obtained vaginal swabs. Poster presentation. Poster presentation at the Annual meeting of the Society for Gynecologic Investigation. Chicago IL, March 25, 2000. *J Soc Gynecol Invest* 2000; 7(1) suppl (abstract #840).

21. Pastore LM, Wells E, **Thorp JM**, Kuller J, Hulka BS. Bacterial vaginosis in postmenopausal women: prevalence, symptoms and diagnostic implications. Presented at 21st Annual Meeting of the Southern Gerontological Society, Raleigh NC, April, 2000.

22. Savitz D, Wilkins D, Rollins D, **Thorp JM**, Henderson L, Dole N. Hair as an indicator of cocaine use during pregnancy and risk of preterm birth. Poster presentation at the Annual Meeting of the Society for Epidemiologic Research, June 2000, Seattle WA. Am J Epidemiol 2000;151:S7 (abstract #25).

23. Gavin NI, **Thorp JM**. Medical care costs associated with postmenopausal hormone replacement therapy. Accepted for poster presentation at the World Congress on Osteoporosis 2000. Chicago, IL, June 15-18, 2000.

24. Pastore LM, Wells E, **Thorp JM**, Kuller J, Hulka BS. Bacterial vaginosis in postmenopausal women: prevalence, symptoms and diagnostic implications. Poster presentation at the Southern Gerontological Society, April, 2000.

25. Pastore LM, **Thorp JM**, Dawson IJ. Public health clinic use of antenatal bacterial vaginosis risk score. Accepted for poster presentation to International Federation of Gynecology and Obstetrics XVI World Congress Conference, Washington DC, September, 2000.

26. Saldana TM, Seiga-Riz AM, Adair LS, Savitz DA, **Thorp JM**. Women with impaired glucose status during pregnancy have heavier babies. Poster presentation at the

Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Toronto, CAN, June 2001.

27. Saldana TM, Siega-Riz AM, Adair LS, Savitz DA, **Thorp JM**. The association between impaired glucose tolerance and birth weight among black and white women in central North Carolina. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Toronto, CAN, June, 2001.

28. Siega-Riz AM, Savitz DA, **Thorp JM Jr**, Zeisel S. Is there an association between maternal folate status in the second trimester and preterm birth? Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research. Toronto, CA, June 2001

29. Connolly AM, **Thorp JM**, Pahel-Short L, Copeland K. Effects of pregnancy and childbirth on postpartum sexual function. Poster presentation. American Urogynecology Society Annual Meeting, October, 2001, Chicago, IL.

30. Connolly AM, **Thorp JM**, McMahon M, Pahel-Short L, Wells E. Pregnancy, Childbirth, and Postpartum Bladder Function. Poster presentation at the American Urogynecologic Society Annual Meeting, Hilton Head Island, SC. Oct 26-28, 2000.

31. Whitecar PW, Boggess KA, McMahon MJ, **Thorp JM**, Taylor DD. Comparison of asymmetric, non-precipitating antibodies in preeclampsia to normotensive pregnant controls. Poster presentation at the Twenty-first Annual Meeting of the Society for Maternal-Fetal Medicine, February, 2001, Reno NV.

32. Savitz DA, Terry J, Dole N, **Thorp JM,** Siega-Riz AM, Herring A. Comparison of pregnancy dating by last menstrual period, ultrasound, or their combination. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, June, 2001, Toronto ONT CAN

33. Seiga-Riz AM, Savitz DA, **Thorp JM,** Zeisel S. Is there an association between maternal folate status in the second trimester and preterm birth: Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Toronto, CAN, June, 2001.

34. **Thorp JM**, Gavin NI, Ohsfeldt RL. Hormone replacement therapy in postmenopausal women: Utilization of Health Care Resources by New Users. Presented at the South Atlantic Association of Obstetricians & Gynecologists Annual Meeting, Hot Springs VA, January, 2001.

35. Yang J, Savitz DA, **Thorp JM**, Hartmann KE, Dole N. Predictors of vaginal bleeding in the first two trimesters of pregnancy. Poster presentation at the Annual Meeting of the Society for Epidemiologic Research, Toronto CAN, June, 2001.

36. Berkman ND, **Thorp JM**, Lohr KN, Carey TS, Hartmann KE, Gavin NI, Hasselblad V, Idicula AE. Tocolytic Treatment for the Management of Preterm Labor: A Review of the Evidence. To be presented at the South Atlantic Association of Obstetricians and Gynecologists 64th Annual Meeting, January, 2002.

37. Siega-Riz AM, Hartzema AG, Turnbull C, **Thorp JM**, McDonald T, Cogswell M. A trial of selective versus routine iron supplementation to prevent third trimester anemia during pregnancy. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

38. Balu R, **Thorp JM**, Savitz D, Heine P. Association between cervical length and markers of immune status of the cervico-genital tract during pregnancy. Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

39. Balu R, Savitz D, Ananth C, **Thorp JM**, Heine P, Eucker B. Bacterial vaginosis and vaginal fluid defensins during pregnancy. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

40. Balu R, Savitz D, Ananth C, **Thorp JM**, Heine P, Eucker B. Bacterial vaginosis, vaginal fluid defensins and preterm birth in a cohort of North Carolina women. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

41. Balu R, **Thorp JM**, Savitz D, McMahon M, Hartmann K, Eucker B. Cervical length and the etiologic heterogeneity of preterm birth. Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

42. Savitz D, Terry JW, Dole N, **Thorp JM**, Siega-Riz AM, Herring AH. Comparison of pregnancy dating by last menstrual period, ultrasound, or their combination. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

43. Malizia B, **Thorp JM**, Siega-Riz AM, Savitz D, Hartmann K, Eucker B. Identification of perinatal substance use in clinical care. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

44. Siega-Riz AM, Savitz D, **Thorp JM**, Zeisel S, Hartmann K, Eucker B. Is there an association between maternal folate status in the second trimester and preterm birth? Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

45. Dole N, Savitz D, Siega-Riz AM, McMahon M, **Thorp JM**, Eucker B. Psychosocial factors and preterm birth among African-American and white women in central North Carolina. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

46. Siega-Riz AM, Promislow J, Savitz D, **Thorp JM**, Hartmann K, Eucker B. Vitamin C intake and the risk of preterm birth. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA. January 17, 2002.

47. Evenson KR, Siega-Riz AM, Savitz DA, Leiferman JA, and **Thorp JM**. Vigorous leisure activity and pregnancy outcome: The Pregnancy, Infection, and Nutrition Study. Poster at the American College of Sports Medicine meeting in St. Louis, MO, May 31, 2002. Abstract in Med Sci Sport Exercise. 2002;34(5) Supplement.

48. Pompeii LA, Savitz DA, Evenson KR, Loomis D, Rogers B, **Thorp JM**. Cessation of employment and the risk of preterm delivery and small-for-gestational age birth. Third International Congress of Women, Work, and Health. Stockholm Sweden, June, 2002.

49. Savitz DA, Dole N, Herring AH, Kaczor DA, Murphy J, Siega-Riz AM, **Thorp JM Jr**. Risk factor profile of spontaneous and medically indicated preterm births. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Palm Desert CA, June, 2002.

50. Vahratian A, Siega-Riz AM, Savitz DA, **Thorp JM Jr**. Multivitamin use and the risk of preterm birth. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Palm Desert CA, June, 2002.

51. Murphy J, Dole N, Savitz DA, Herring A, Kaczor D, Siega-Riz AM, **Thorp JM**. Perinatal factors associated with both intermediate and positive bacterial vaginosis in pregnancy. Poster presentation at the 23rd Annual Meeting of the Society of Maternal-Fetal Medicine, San Francisco CA, February, 2003.

52. Murphy J, Dole N, Savitz DA, Herring A, Kaczor D, Benson A, Siega-Riz AM, **Thorp JM**. Decision to delivery in preterm preeclampsia: Maternal or fetal indications. Poster presentation at the 23rd Annual Meeting of the Society of Maternal-Fetal Medicine, San Francisco CA, February, 2003.

53. Savitz DA, Kaufman JS, Dole N, Siega-Riz AM, **Thorp JM Jr**, Kaczor DT. Poverty, education, race, and pregnancy outcome. Poster presentation at the Annual Population Association of America Meeting, Minneapolis MN, May, 2003.

54. Vahratian A, Zhang J, Hasling J, Troendle J, Klebanoff M, **Thorp JM**. Early Analgesia and Labor. Poster Presentation: Society for Pediatric and Perinatal Epidemiologic Research, Atlanta, Ga, June 10-11, 2003.

55. Yang J, Savitz DA, Dole N, Hartmann KE, Herring AH, Olshan AF, Thorp JM Jr. Predictors of vaginal bleeding during pregnancy/ poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Atlanta GA, June, 2003.

56. Salafia C, **Thorp JM**, Maas E, Eucker B, Smith F, Savitz D. Umbilical cord insertion and timing of delivery: 3 measures of relative umbilical cord insertion account for 29% of gestational age variance. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans, LA, February 4, 2004.

57. Salafia C, **Thorp JM**, Maas E, Eucker B, Smith F, Savitz D. Measures of Relative Umbilical Cord Insertion Account for 26% of Birthweight Variance. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans LA, February 4, 2004.

58. Salafia C, Maas E, **Thorp JM**, Eucker B, Smith F, Savitz D. Chorionic Plate Measures Account for 39% of Birthweight Variance. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans LA, February 4, 2004.

59. Salafia C, Mass E, **Thorp JM**, Eucker B, Smith F, Savitz D. Measures of Chorionic Plate area Account for 45% of Gestational Age Variance. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans, LA, February 4, 2004.

60. Vahratian A, Zhang J, Hasling J, Troendle J, Klebanoff M, **Thorp JM**. Effects of Early Epidural Analgesia vs IV Analgesia on Labor Progression: A Natural Experiment. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans, LA, February 4, 2004.

61. Vahratian A, Zhang J, Troendle J, Siega-Riz AM, Savitz D, **Thorp JM**. Maternal obesity and labor progression in nulliparous Women. Poster presentation at the Annual Meeting of the Society for Maternal-Fetal Medicine. New Orleans, LA, February 4, 2004. Am J Obstet Gynecol 2003;189(6 Suppl1):S202.

62. Savitz DA, Dole N, Siega-Riz AM, Kaczor DA, Kaufman J, Herring AH, **Thorp JM**. Probability samples or clinic populations to study pregnancy and children's health? Contrasting approaches of demography and epidemiology. Oral presentation at the Annual population Association of America Meeting, Boston, MA, April, 2004.

63. Fogleman K, Herring A, Jo H, Pusek S, **Thorp JM**. Factors that influence the timing of spontaneous labor at term. Annual Clinical Meeting, Philadelphia PA, May, 2004.

64. Dole N, Herring AH, Savitz DA, **Thorp JM**. Corticotropin-releasing hormone (CRH) perceived stress, and preterm birth. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Salt Lake City UT, June, 2004.

65. Herring Ah, Liao X, Savitz DA, Dole N, Evenson K, Thorp JM. Time-varying coefficient models for preterm birth. Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Salt Lake City UT, June, 2004.

66. Harville E, Savitz Da, Dole N, **Thorp JM**, Predictors of placenta resistance. Oral presentation at the Annual Meeting of the Society for Epidemiologic Research. Salt Lake City UT, June, 2004.

67. Harville E, Dole N, **Thorp JM**, Savitz DA. Diurnal patterns of cortisol. Poster presentation at the Annual Meeting of the Society for Epidemiologic Research, Toronto CAN, June 2005.

68. Siega-Riz AM, Savitz DA, Kaczor D, Herring A, **Thorp J**. Serum transferring receptor and preterm birth. Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Toronto, CAN, June, 2005.

69. Harville E, Dole N. **Thorp JM**, Savitz DA. Stress and uterine dopplers. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiology, Toronto CAN, June, 2005.

70. Harville E, Dole N, Savitz DA, Herring AH, **Thorp J**. Stress questionnaires and stress biomarkers during pregnancy: Do they measure the same thing? Poster presentation at the 19th Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Seattle WA, June, 2006.

71. Salafia CM, Pezzullo JC, **Thorp JM**, Eucker B. Pijnenborg R, Savitz DA. Basal plate uteroplacental vasculature in a birth cohort: measurement methods and analyses. Poster presented at 19th Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Seattle WA, June, 2006.

72. Siega-Riz AM, Howard DL, Savitz DA, **Thorp J**. The association between dyslipidemia and preterm delivery. Oral presentation at the 19th Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Seattle, WA, June, 2006.

73. Rouse, Dwight and the MFMU Network: A randomized controlled trial of magnesium sulfate for the prevention of cerebral palsy. Abstract #1. Plenary Session 1 at the 28th Annual Meeting of the Society for Maternal Fetal Medicine, Dallas TX, January 28, 2008.

74. Chireau M, Crosslin D, Hauser E, Olshan A, Zheng S, Salafia C, Thorp J. Endothelial function gene polymorphisms are associated with pregnancy outcomes, indepent of placental vascular disease. (Abstract #668). Poster presentation at the 29th Annual Meeting of the Society for Maternal Fetal Medicine, Dallas TX, January 29, 2008.

75. Rouse, D for the NICHD MFMU Network. A Randomized controlled trial of magnesium sulfate for the prevention of cerebral palsy. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

76. Tita, A for the NICHD MFMU Network. The MFMU Cesarean Registry: Impact of gestational age at elective repeat cesarean on neonatal outcomes. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

77. Harper, M for the NICHD MFMU Network. A Randomized controlled trial of Omega-3 fatty acid supplementation for recurrent preterm birth prevention. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

78. Mertz, H for the NICHD MFMU Network. Placental eNOS in multiple and single dose bethamethasone exposed pregnancies. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

79. Bakhshi, T for the NICHD MFMU Network. Maternal and neonatal outcomes of repeat cesarean delivery in women with a prior classical versus low transverse uterine incision. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

80. Rouse, D for the NICHD MFMU Network. When should labor induction be discontinued in the latent phase? Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

81. Varner, M for the NICHD MFMU Network. Can fetal oxygen saturation identify chorioamnionitis? Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

82. Contag, S for the NICHD MFMU Network. Operative vaginal delivery versus cesarean delivery in the second stage of labor. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

83. Rogers, B for the NICHD MFMU Network. Placental pathology associated with the factor V leiden mutation. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

84. Aagard-Tillery, K for the NICHD MFMU Network. Hazardous air pollutants and risk of adverse pregnancy outcomes. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

85. Joy, S for the NICHD MFMU Network. Latency and infectious complications following preterm premature rupture of the membranes: Impact of body mass index. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

86. Sciscione, A for the NICHD MFMU Network. Perinatal outcomes in women with twin gestations who conceived spontaneously versus by assisted reproductive techniques. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

87. Caritis, S for the NICHD MFMU Network. Relationship of 17? Hydroxyprogesterone Caproate (17-OHPC) Concentrations and Gestational Age at Delivery in Twins. Presented at the 55th Annual Scientific Meeting for Society of Gynecologic Investigation, San Diego, CA, March 2008.

88. Caritis, S for the NICHD MFMU Network. Impact of Body Mass Index (BMI) on Plasma Concentrations of 17 ? Hydroxyprogesterone Caproate (17-OHPC). Presented at the 55th Annual Scientific Meeting for Society of Gynecologic Investigation, San Diego, CA, March 2008.

89. Simhan, H for the NICHD MFMU Network. The Effect of 17-alpha Hydroxyprogesterone Caproate (17-OHPC) on Maternal Plasma CRP Levels in Twin Pregnancies. Presented at the 55th Annual Scientific Meeting for Society of Gynecologic Investigation, San Diego, CA, March 2008.

90. Cormier, C for the NICHD MFMU Network. Relationship between Severity of Maternal Diabetes and VBAC Success in Women Undergoing Trial of Labor. Presented at the 55th Annual Scientific Meeting for Society of Gynecologic Investigation, San Diego, CA, March 2008.

91. Rouse D, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Magnesium sulfate (MgSO4) dose and timing, and umbilical cord Mg++ concentration: Relationship to cerebral palsy (CP) Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

92. Mercer B, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Fetal thyroid function and neuro-

developmental outcomes. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

93. Roberts JM, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. A randomized controlled trial of antioxidant vitamins to prevent serious preeclampsia-associated morbidity. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

94. Rouse D, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Second stage labor duration: Relationship to maternal and perinatal outcomes. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

95. Silver R, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Prothrombin gene G20210a mutation and obstetric complications: A propsective cohort. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

96. Manuck T, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Do antiphospholipid antibodies affect pregnancy outcomes in women heterozygous for factor v leiden? Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

97. Landon MB, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. A prospective multicenter randomized treatment trial of mild gestational diabetes (GDM). Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

98. Harper M, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Effect of omega-3 supplementation on plasma fatty acid levels. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

99. Harper M, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, Maryland. Cytokine gene single nucleotide polymorphisms (SNPS) and length of gestation. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

100. Hickman A, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. The MFMU cesarean registry: Risk of rupture in women attempting VBAC with an unknown uterine scar. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

101. Hashima J, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. The effect of maternal obesity on neonatal outcome in women receiving a single course of antenatal corticosteroids.

Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

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116. Berner M, Nappi R, Thorp JM, Jolly E, Sand M**.** Efficacy of Flibanserin in Premenopausal Women with Hypoactive Sexual Desire Disorder: Remitter Analyses. Poster presentation at European Society for Sexual Medicine.

117. Hauth JC, et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Maternal insulin resistance and preeclampsia. Oral presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

118. Figueroa D, et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Relationship between the 1-hur glucose loading test results and perinatal outcomes. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

119. Clark EAS, et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network.

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122. Harper M. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Tumor necrosis factor α -308 genetic polymorphism and cytokine production. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

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127. Stuebe A. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Is there a threshold OGTT value for predicting adverse neonatal outcome? Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

128. Johnson J. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network.

Outcomes associated with failure to achieve the 2009 Institute of Medicine (IOM) guidelines for weight gain in pregnancy. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

129. Varner M. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Influenza-like illness in hospitalized pregnancy and immediately postpartum women during the 2009-2010 H1N1 influenza pandemic. Oral presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 12, 2011.

130. Graves SW, Esplin MS et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Validation of predictive preterm birth biomarkers obtained by maternal serum proteomics. Oral presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

131. Carreno C. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Excessive early gestational weight gain and risks of gestational diabetes and large for gestational age infants in nulliparous women. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

132. Hauth JC. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Insulin resistance in pregnancy and maternal body mass. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

133. Griffin JB, Lomboka V, Landis SH, Herring Am, Thorp JM Jr, Tshefu AK, Meshnick SR. Malaria in early pregnancy and in utero fetal growth. Presented at the Tropical Medicine conference, December, 2011.

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International Journal of Obstetrics and Gyneacology audio podcast entitled **"Termination of pregnancy and the risk of subsequent preterm birth – what is the evidence?"**

Publications

Peer Reviewed Articles

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5. **Thorp JM**, Katz VL, Fowler LJ, Kurtzman JT, Bowes WA Jr. Fetal Death from chlamydial infection across intact amniotic membranes. *Am J Obstet Gynecol* 1989;161:1245-6.

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Non-Peer Reviewed Articles

1. **Thorp JM.** Should episiotomy be routine? *Current Practices* 8:3, December 1988.

2. **Thorp JM.** Should we routinely screen for toxoplasmosis? *Current Practices* 10:6, September 1990.

3. **Thorp JM**. Endovaginal sonography. *Current Practices* 12(4):1-2, December 1991.

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5. Hansen WF, **Thorp JM**. Postterm pregnancy. *Current Practices* 13 (1):1-2, March 1992.

6. **Thorp JM**, Stanford D. The Horizons program: a perinatal substance abuse project. *Current Practices* 13(2):6, June, 1993.

7. Kurtzman JL, **Thorp JM**, Spielman FJ, Mueller RC, and Cefalo RC. Do Nifedipine and Verapamil Potentiate the Cardiac Toxicity of Magnesium Sulfate? *Obstetric Anesthesia Digest*, 14(2) 45-92, 1994.

8. **Thorp, JM**. Patient Autonomy, Informed Consent, and Routine Episiotomy. *Contemporary OB/GYN*, September, 1995.

9. **Thorp, JM**. Point/Counterpoint: Should physicians with strong pro-life views avoid specializing in perinatology? No. *Physicians Weekly*, 12 (23); April 19, 1995.

10. **Thorp, JM**. Challenging Cases as a preceptor. *The Front Line* 1; 3-4, Summer, 1995.

11. **Thorp, JM**. Is episiotomy necessary? *Health Confidential*, 1995.

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16. Guise J-M, **Thorp JM.** Antibiotics in the Management of Preterm Premature Rupture of Membranes. *Current Practices* 16;4, 1996.

17. **Thorp, JM.** Should I Incorporate Fetal Fibronectin into my Practice; and if so, How? *OBG Management*. Accepted, Sept, 1996.

18. **Thorp JM**, Cefalo RC, Bowes WA Jr. Court-ordered obstetrical intervention. *Contemporary OB/GYN*. June, 1997.

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21. Dorman K, **Thorp JM**. Improving Access to UNC Clinicians. *Current Practices*, September, 1998.

22. Cefalo RC, **Thorp JM.** Videotaping in Labor and Delivery. *Current Practices*, September, 1998.

23. **Thorp JM.** I Want To Be Like Watt. *Current Practices*, March, 1999.

24. **Thorp JM**. Literature Review and Study Design: Resource use associated with hormone replacement therapy. Research Triangle Institute project report funded by Eli Lilley, January 1999.

25. Gavin N, Wilson A, Greene Al, West, S, **Thorp JM**. Health Care Resource Use Associated with Hormone Replacement Therapy. Research Triangle Institute Report Project No 7203, funded by Eli Lilley, November, 1999.

26. **Thorp JM**. No role for maintenance tocolysis in preterm labour: study. Obstet & Gynaecol Canada. November, 2000, Vol 4, No. 7, p 13.

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30. Sayle A, Savitz D, **Thorp JM**. Sexual intercourse and orgasm during late pregnancy may have a protective effect against preterm delivery. Family Planning Perspective 2001;33(4):185.

31. **Thorp JM**. Integrity, Abortion, and the Pro-Life Perinatologists. Proceedings of World Federal of Catholic Medical Associations, "The Future of Obstetrics and Gynaecology: The Fundamental Human Right to be Trained and to Practice According to Conscience". Marie S.S. Bambina Institute, Rome, Italy, 2001.

32. Ansbacher R, Creinin MD, **Thorp JM**, Nolan TE, Thorneycroft IH. Therapeutic substitution of low-dose OCs. *The Female Patient* 2002;27:11-12.

33. **Thorp JM**. Predicting and preventing preterm birth. *OBG Management* 2005;17 (6):49-53.

34. **Thorp JM Jr**, Rowland Hogue CJ, Does elective abortion increase the risk of preterm delivery? *Contemporary OB/GYN: Controversies in OB/GYN* 2006(September)51(9):88-92.

35. **Thorp JM Jr**. Does cervical dysplasia raise the risk of preterm birth? Examining the Evidence (commentary). *OBG Management* 2007:19(40:20-23.

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Teaching Activities

Faculty Committees	1. Tenured Medicine Council 2. Faculty Executive Committee(alternate)	2007
Liaison	Area Health Education Center Liaison School of Medicine University North Carolina-Chapel Hill	2000-2003
Member	Doctoral Dissertation Committees Department of Epidemiology School of Public Health	1997-present

	University North Carolina-Chapel Hill	
Oral Examiner	American Board Obstetrics and Gynecology MFM Subspecialty	2005 - present
Oral Examiner	American Board Obstetrics and Gynecology	1996-present
Fellowship Director	Division of Maternal-Fetal Medicine Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	1997-2000

Grants

Cooperative agreement in community child Study proposes to do community based participatory research in Eastern NC. (Thorp 5%) Principal Investigator: John M. Thorp Source: NICHD Funding: $600,000	1/2002 - 1/2006
Epidemiology of Leptin Production and Fetal Growth. This study's goal is to understand the Determinants of fetal growth in human pregnancy, With the focus on growth potential to the growth that Is attained with respect to leptin production. (Thorp 13% yr 1) Principal investigator: John M. Thorp Source: NIH Funding Period: 9/2004-9/2009 Funding: 5,500,000 – Awaiting resubmission	9/2004 – 9/2009
Pregnancy-Related Weight Gain: A Link to Obesity. This study's goal is to identify modifiable behaviors for pregnant women that are associated with weight gain above the recommended ranges and that result in high postpartum weight retention. (Thorp 5%) Principal Investigator: Anna Maria Siega-Riz, PhD Source: NIH/NIDDK Funding Period: 08/01/02 – 07/31/07 Funding: Total Direct: $1,749,033	8/01/02 –7/31/07
Placental Vascular Compromise and Preterm Delivery: This study will look at the association between placental vascular compromise and preterm delivery rates. (Thorp 20% in year 1) Principal Investigator John Thorp MD Source: NICHD/NIH 1 RO1 HD39373-0A1.	9/01/01-8/31/06

Funding Period: 9/01/01-8/31/06
Funding: Total Direct: $2,350,497
Current Year Funding $510,996

Cooperative Multicenter Maternal Fetal Units Network: This study proposes to conduct clinical trials in perinatal medicine (Thorp 10%) — 4/1/01 – 3/ 31/06
Principal Investigator: John Thorp Jr. M.D.
Source: NIH: Grant No. 1 U10 HD40560-01
Funding Period: 4/1/01 – 3/ 31/06
Funding: $ 1,459,785
Current Year Funding $ 272,087

Gates Global Network to Improve Maternal Health. This is a collaborative, multicenter, global network that will investigate clinician behavior regarding episiotomy and oxytocin use in Uruguay and Argentina in conjunction with the Center for Latin American Perinatology. (Thorp 7.5%) — 1/01/01-1/01/06
Principal Investigator: Pierre Buekens, MD, PhD
Source: NICHD
Project Period: 1/01/01-1/01/06
Total Funding: $2,800,000
Type: Research

Epidemiologic Study of Vaginal Bleeding during Pregnancy and Preterm Birth. The proposed study extends an NIH-funded study of epidemiology of exertion, stress, and pre term birth. Detailed information regarding vaginal bleeding will be added to the interviews for all enrolled women administered after recruitment and at 27-30 weeks' gestation. (Thorp 0%) — 6/01/01-5/31/04
Principal Investigator: David Savitz PhD
Source: March of Dimes
Funding Period: 6/01/01-5/31/04
Total Direct Costs: $163,258 Total Indirect Costs: $16,326 Total Funding: $179,584
Current Year Funding: $61,405

Epidemiology of Exertion, Stress and Preterm Delivery. In this study, it is proposed that the role of external stressors, perceived stress, enhancers and buffers of perceived stress, and physiologic markers of response to stress be examined in relation to pregnancy outcome. A detailed evaluation of domestic, occupational and recreational physical activity patterns before and during pregnancy will be conducted. (Thorp 5%) — 12/1/99-11/30/04
Principal Investigator: David A. Savitz, PhD.
Source: NICHD/NIH RO1-HD3758

Total Project Period: 12/1/99-11/30/04
Total Funding: $3,735,28 Direct: $2,586,817
Indirect: $1,148,464
Current Year Funding: $385,179

Drinking Water Disinfection By-Products and Spontaneous Abortion – this prospective cohort study will test the hypothesis that water disinfection by-products, particularly trihalomethanes and haloacetic acids are associated with increased rise of early spontaneous pregnancy loss. Approximately 3,000 women, in three distinct water supplier regions will be enrolled in early pregnancy or prior to conception. First trimester ultrasound data, as well as supplementary studies of time to conception, and the grief counseling needs of women with poor pregnancy outcomes will be based at the Sheps Center. (Supported by a grant to the Department of Epidemiology. (Thorp 5% in-kind) 11/15/99-06/15/02
Principal Investigator: David A. Savitz, PhD
Source: American Water Works Association Research Foundation AWWARF Grant No. 2579
Total Project Period: 11/15/99-06/15/02
Total Funding:$3,000,000
Direct: $1,668,000 Indirect: $1,332,000
Current Year Funding: Direct: $1,287,677.00
(30 month budget – Year 1 budget)
Type: Research

Psychosocial Risks and Preterm Birth in African-American Women. It is proposed that this study evaluates the role of external stressors perceived stress, enhancers and buffers of perceived stress in relation to pregnancy outcome. Building on an ongoing study of preterm delivery, an additional 550 women will be enrolled who obtain prenatal care at the University of North Carolina Hospitals' clinics between the 24th and 29th weeks of gestation. External stressors (life events, physical and emotional abuse, job stress, socioeconomic stress), perceived stress (impact of life events, discrimination, and safety), enhancers (anxiety, depression) and buffers social support, coping, religion) will be evaluated during pregnancy. (Thorp 3%) 9/09/99-9/08/02
Principal Investigator: David Savitz PhD
Source: ASPH S0807-18/20
Total Project Period: 9/09/99-9/08/02
Total Direct Costs: $179,892. Total Indirect Costs: $76,949 Total Funding: $256,841
Current Year Funding: $53,652

Model Program for Perinatal Substance Abuse 1/01/94 – Present
HORIZONS.
This is a demonstration projectof a novel paradigm
to treat perinatal substance use problems by combining
perinatal and mental health care. It combines an array of
treatment resources including a residential program in which
families can receive substance abuse treatment.
(Thorp 10%)
Principal Investigator: John M. Thorp, Jr., MD
Source: NC Department of Health
and Human Services
Project Period: 1/01/94 – Present
Funding to Date: $4,500,000

Past Support

Influence of iron, zinc, and folate on 1999-2001
preterm delivery
Funding Agency: NICHD/NIH
Co-Investigator
$570,000

Addiction Studies, Center for Welfare 1998-2001
reform and perinatal substance abuse
Funding Agency: RW Johnson
Medical Director
$800,000

Evidence based management of Preterm Labor 1998-1999
Funding Agency: AHRQ
Scientific Director
$200,000

Perinatal iron metabolism 1996-1999
Funding Agency: CDC
Co-Principal Investigator
$386,000

Epidemiology of cocaine use 1996-1999
Funding Agency: NICHD
Co-Principal Investigator
$78,000

Perinatal HIV Prevention 1996-1997
Funding Agency: CDC
Co-Principal Investigator
$120,000

Perinatal smoking cessation 1993-1995
Funding Agency: Kate B. Reynolds

Charitable Trust
Medical Director
$109,000

Smoking cessation — 1995-1997
Funding Agency: R.W. Johnson
Principal Investigator
$205,000

Professional Service

Specialty and Sub-Specialty Certification

Sub-Specialty certification, Gynecology — 1992-present
American Board of Obstetrics and Gynecology

Diplomate — American Board of Obstetrics and Gynecology — 1991-present
Maternal-Fetal Medicine

Committee Assignment

University of North Carolina in Chapel Hill — 2003 - 2005
Appointment to promotion with tenure
Chapel Hill, NC

Proposal Reviewer

Member — Study Section – Maternal & Child Health — 2002 - present
NICHD, Bethesda, MD

Member — Steering Committee, MFMU Network — 2001 - present
CHD, Bethesda, MD

Member — Expert Review Panel – Evidence report on post-term pregnancy — 2001 - 2002
Duke University, Durham, NC

Proposal Reviewer — Family Health International — 2000 - present
RTP, NC

Member — Special emphasis group on regional anesthesia — 1999
NICHD, Bethesda, MD

Rev: April 2011